MAPLETON PUBLIC SCHOOLS
OVERNIGHT HEALTH QUESTIONNAIRE

Student Name: ____ Today's Date: _____________________________
School: __________________________Grade: _________________ Sex: ____ Birth Date: ________________
Guardian(s): ____ Home Phone: ______________________________
Health Care Provider: ______________________________________ Work Phone: _______________________________
Primary language spoken in the home: ________________________ Pager/Cell Phone: __________________________

	Past	Present	N/A	If YES, please explain:
Asthma/Respiratory Difficulties				
Moderate/Severe Asthma				
ADD/ADHD				
Allergies				
Severe allergies to food, insects, latex				
Bladder/Kidney Problems				
Bowel Problems (constipation, diarrhea, colostomy, etc.)				
Blood Disorders				
Bone, Joint or Muscle Problems (Cerebral palsy, arthritis, etc.)				
Cancer				
Diabetes				
Frequent Headaches				
Frequent Ear Infections				
Frequent Throat Infections				
Genetic Condition				
Head Injury				
Hearing Loss/Hearing Aids				
Heart Problems				
Hospitalization/Surgery				
Neurological Disorder (tremors, Spina Bifada, Muscular Dystrophy, etc.)				
Physical Disability				
Seizure Disorder				
Serious Accidents, Illnesses, Injury				
Shunts				
Stomach/Digestive Problems				
Thyroid Disorder				
Vision Problems (inc. glasses or contacts)				

Restrictions: Has the doctor restricted your child's activities for medical reasons? YES / NO (circle one) If YES, please describe: ____

Medications/Medical Procedures:

1. Does your child require any specific medical equipment for overnight field trips (i.e. wheelchair, feeding tube, nebulizer, oxygen, etc.)? YES / NO (circle one) If YES, please explain: _______________________________________
2. Does your child take daily medications? YES / NO (circle one) If YES, please list (including medication name, dosage and frequency): ____
3. Will your child require medication during the overnight field trip? YES / NO (circle one) If YES, please complete the medication permission form.
4. Does your child have a health care plan with the school nurse on file at his/ her school? YES / NO (circle one).

I understand all the information within may be shared with school personnel if the information provided may impact the student's educational experience and/or safety. As the parent/guardian of ______________________________, I give permission for this information to be shared with school personnel as deemed necessary.

____
(Parent's Signature).

Reviewed by ______________________________/____/20____Reviewed by ______________________________/____/20___

ESCUELAS PUBLICAS DE MAPLETON
DURANTE LA NOCHE CUESTIONARIO DE SALUD

Nombre del estudiante: ______________________________________ Fecha de hoy :__________________________
Escuela: _________________________Grado: __________ Sexo: ____ Fecha de nacimiento: _____________________
Nombre del/de los padre(s): __________________________________ N0. de teléfono (casa): _____________________
Doctor de cabecera: ____ N0. de teléfono (oficina):__________________
Idioma principal hablado en casa: ______________________________ Pager/Celular: ____________________________

Información de salud:

	Pasado	Presente	ESTE NO	Si elige "Sí", por favor explique a continuación:
Asma / Dificultades respiratorias				
Asma severas				
ADD /ADHD				
Alergias				
Alergias severas a los alimentos, insectos, látex				
Problemas de vejiga / riñón				
Problemas intestinales (constipación, diarrea, Colostomía, etc.)				
Trastornos sanguíneos				
Problemas óseos, en las articulaciones, musculares (parálisis cerebral, artritis, etc.)				
Cáncer				
Diabetes				
Dolor de cabeza frecuente				
Infecciones del oído frecuentes				
Infecciones de la garganta frecuentes				
Trastornos genéticos				
Lesiones en la cabeza				
Pérdida de la audición / prótesis auditivas				
Problemas cardiacos				
Hospitalizaciones / cirugías				
Trastornos neurológicos (temblores, espina bífida, distrofia muscular, etc.)				
Discapacidad física				
Apoplejía				
Accidentes graves, enfermedades, lesiones				
Shunts (desviaciones)				
Problemas estomacales / digestivos				
Problemas de la tiroides				
Problemas de la visión (anteojos o lentes de contacto)				

Restricciones:¿Ha restringido su doctor, por algún motivo médico, las actividades de su niño? SI / NO (encerrar en un círculo). Si elige "SI", por favor explique a continuación: ____.

Medicaciones / Procedimientos médicos:

1. ¿Requiere su niño algún tipo de equipo médico específico en a escuela (ej.: silla de ruedas, tubo de alimentación, nebulizador, oxígeno, etc.)? SI / NO (encerrar en un círculo). Si elige "SI", por favor explique a continuación: ____
2. ¿Toma su niño medicaciones diariamente? SI / NO (encerrar en un círculo). Si elige "SI", por favor haga una lista (incluyendo el nombre de la medicación, la dosis y la frecuencia de consumo):_______________________________
3. ¿Requiere su niño tomar medicaciones durante el horario escolar? SI / NO (encerrar en un círculo). Si elige "SI", por favor llene el formulario de autorización para recibir medicaciones en la escuela.

Comprendo que esta información puede compartirse con el personal de la escuela si se concluye que la misma puede tener un impacto beneficioso en la experiencia educativa o la seguridad del estudiante. Como padre / tutor de ______________________________, doy autorización a la escuela para que comparta esta información con el personal, según considere conveniente. _______________________________________ **(Firma del padre).**

Reviewed by _______________________________/____/20____Reviewed by _______________________________/____/20___

MAPLETON PUBLIC SCHOOLS
OVER NIGHT FIELD TRIP HEALTH QUESTIONNAIRE

Student Name: ____ Date: ____________________________

School: __________________________Grade: _________________ Sex: ____ Birth Date: ________________

Guardian(s): ____ Home Phone: ____________________________

Health Care Provider: _____________________________________ Work Phone: _____________________________

Primary language spoken in the home: _______________________ Pager/Cell Phone: _________________________

	PAST	PRESENT	N/A	If YES, please explain:
Asthma/Respiratory Difficulties				
Moderate/Severe Asthma				
ADD/ADHD				
Allergies				
Severe allergies food, insects, latex				
Bladder/Kidney Problems				
Bowel Problems (constipation, diarrhea, colostomy, etc.)				
Blood Disorders				
Bone, Joint or Muscle Problems (Cerebral palsy, arthritis, etc.)				
Cancer				
Diabetes				
Frequent Headaches				
Frequent Ear Infections				
Frequent Throat Infections				
Genetic Condition				
Head Injury				
Hearing Loss/Hearing Aids				
Heart Problems				
Hospitalization/Surgery				
Neurological Disorder (tremors, Spina Bifada, Muscular Dystrophy, etc.)				
Physical Disability				
Seizure Disorder				
Serious Accidents, Illnesses, Injury				
Shunts				
Stomach/Digestive Problems				
Thyroid Disorder				
Vision Problems glasses or contacts				

Restrictions: Has the doctor restricted your child's activities for medical reasons? YES NO (Circle One)

If YES, please describe: ____

Medications/Medical Procedures:

1. Does your child require any specific medical equipment (i.e. wheelchair, feeding tube, nebulizer, oxygen, etc.)? YES / NO (circle one). If YES, please explain: ____
2. Does your child take daily medications? YES / NO (circle one) If YES, please fill out "Parent's Request for Giving Medications at School" (Turn over) This includes all medications, including Tylenol, Ibuprofen, Tums, cough syrup, allergy pills, and controlled meds.
3. For every medication the student needs, please have your health care provider sign the form and either take to health office or fax to: ______________ (One form per med)
4. Does your child have a health care plan on file at his/ her school? YES / NO (circle one).

I understand all the information on this document may be shared with school personnel if it is determined that the information provided may impact the student's educational experience and/or safety. As the parent/guardian of __________________________. I give permission for this information to be shared with school personnel as deemed necessary.

____

Parent's Signature

Reviewed by ________________________________/____/20____Reviewed by ________________________________/____/20___

File: JLCD-E

MAPLETON PUBLIC SCHOOLS

PARENT'S REQUEST FOR GIVING MEDICATION AT SCHOOL

I request that my child ____ receive the medication prescribed
(Child's Name)

by ____ at __________________________ for
(Physician's Name) (Telephone Number)

the period from ____________________________________ to ____________________________________
(Starting Date) (Ending Date)

according to the Health Care Provider's signed instructions on the lower part of this form.

Prescription medications must come in a container labeled with: child's name, name of medicine, when medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

Over the counter medication must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. In consideration of the acceptance of the request to perform this service by any authorized person employed by the Mapleton Public School District, the undersigned parent/guardian hereby agrees to release the Mapleton Public School District and its personnel from any legal claim which they now have or may hereafter have arising out of the administration of or failure to administer the medication to the student.

I hereby give my permission for the above named student to take the prescription listed below at school or school sponsored activities as ordered. I understand that it is my responsibility to furnish this medication.

____

Signature of Parent/Guardian Date

HEALTH CARE PROVIDER AUTHORIZATION

Child's Name: ____ **Birth date:** ________________

Name of Medication: ____

Dosage: ____ **Route:** __________________________

To be given at school at the following time(s): ____

Special Instructions: ____

Purpose of medication: ____

Side effects that need to be reported to the parent: ____

____ _________________________

Signature of Health Care Provider with Prescriptive Authority) Date

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SCHOOL APPROVAL

School: ____

____ **Date:** _____________________

(Principal's or Designee's Signature)

Copy faxed to School Nurse Consultant at 303-853-1145 by: ________ Date: _____________________

Please ask the pharmacist for a separate medication bottle to keep at school

Reviewed by ______________________________/____/20____Reviewed by ______________________________/____/20___